

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC		<b>Response Timely Filed?</b> ( ) Yes (X) No	
Requestor Vista Medical Center Hospital 4301 Vista Rd. Pasadena, TX 77504		MDR Tracking No.: M4-05-0525-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's American Casualty Co. Rep. Box # 47		Date of Injury:	
		Employer's Name:	
		Insurance Carrier's No.: 3A808047	

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-31-03	11-2-03	Inpatient Hospitalization	\$36,331.60	\$1163.50

## PART III: REQUESTOR'S POSITION SUMMARY

G – Unbundling for this service is prohibited per Fee Guideline; D-Carrier utilized code “D” for charges that were not previously processed by the Carrier; and C - There is no negotiated contractual agreement with the Carrier. Carrier has not provided the proper payment exception code in this instance, which in violation of the TWC Administrative Code. Healthcare provider does not have a negotiated contractual agreement with Carrier.

## PART IV: RESPONDENT'S POSITION SUMMARY

The Requestor has been paid for the services provided to the Claimant, for the accepted compensable injury, pursuant to Respondent's methodology including the time spent in the operating room.

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

C issue: Requestor contends that a contract does not exist between parties. The respondent did not support position that a contract exist and that reduction was appropriate; therefore services will be reviewed in accordance with Rule 134.401.

G issue: The requestor inappropriately billed hospital services separately; services will be reviewed per Rule 134.401.

D issue: The reconsideration bill was a duplicate bill of original bill, services will be reviewed per Rule 134.401.

Rule 134.401 sets out provisions for reimbursement. An inpatient hospitalization may be reimbursed either as a stop-loss, per diem plus carve outs, or fair and reasonable depending on provisions in Rule 134.401.

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for “unusually costly services.” The explanation that follows this paragraph indicates that in order to determine if “unusually costly services” were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve “unusually extensive services.”

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved “unusually extensive services.” Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

M – No MAR issue: As stated above, this hospitalization is applicable to the per diem plus carve-out methodology. Insurance carrier

inappropriately utilized M denial code.

The total length of stay for this admission was 2 days (consisting of 2 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to \$2236.00(2 times \$1,118.00). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

Cost invoices were not submitted to support additional reimbursement per Rule 134.401(c)(4).

The insurance carrier paid \$1,072.50 for the inpatient hospitalization. The difference between amount paid of \$1072.50 and amount due of \$2236.00 = \$1,163.50.

Based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is entitled to a reimbursement amount for these services equal to \$1163.50.

**PART VI: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$1163.50. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

03-30-05

Authorized Signature

Typed Name

Date of Order

**PART VII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_